Doctors and "Off-field Behaviour" – a lawyer's perspective

Outline of response and discussion of Professor Tony Eyer's "Off-field Behaviour" presentation

I want to start by thanking Tony for proposing such an interesting topic, and for his talk, and for raising such interesting questions, which prompt us to explore fundamental questions about what it is that we expect of medical practitioners, and how that has changed to reflect the era that we live in.

I was particularly taken by two of Tony's observations. First, Tony's characterisation of the two bodies co-regulating the profession, positioning the Medical Council as the "Guide Dog", and the HCCC is the "Guard Dog".

1 Guide Dog v Guard Dog

In my years of advocating for doctors both at the Medical Council and the HCCC, I can say that as a broad generalisation, this is true. I have found that where the Medical Council feels that they can work with practitioners to allow them to remain in practice while getting the support they need, they do.

Further, on the whole, the co-regulatory model works remarkably well. The manner in which the legislation requires the two bodies to consult with each other, and the degree of co-operation that appears to foster must be at least part of the explanation.

2 Different expectations of "off-field" behaviour depending on age and position?

Second, Tony makes an important observation that public and collegiate expectations of more senior and experienced practitioners with respect to their behaviour "off the field" will also be higher than it is for more junior practitioners, just as it is with their professional conduct and performance.

It is natural for us to make this connection with respect to practitioners' professional practice and performance, but less obvious with respect to personal conduct.

In this respect, it is worth noting the wording of section 139B(1)(a) of the National Law with its apparent focus upon professional practice rather than conduct outside of work, which states that *"unsatisfactory professional conduct"* includes:

"Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience".

Providing context to the "urgent action" decisions at the heart of Tony's paper

As well as those direct observations about Tony's paper, I wanted to have a little bit of a poke around the National Law, with a focus upon the same "urgent action" provisions which are the centre of Tony's paper, which might allow us to explore a bit further the "on field/off field" distinction, and consider what we might make of it.

The Butcher of Bega

First, let's explore the origin of the current provisions in the National Law, which take their current form largely as the result of several high profile cases of distinctly "on-field" behaviour in which the Medical Council was criticised for failing to take sufficient action to protect the public from harm.

The most notorious of those cases was Dr Reeves, the gynaecologist and obstetrician, who became popularly known as the "Butcher of Bega", who was the subject of countless, deeply troubling complaints over a number of years, and was eventually convicted on a criminal charge of grievous bodily harm after removing a woman's clitoris without her consent.

A tightening of the "urgent action" provisions in response

Prior to 2008, section 66(1) of the *Medical Practice Act* was in the following form:

Suspension or conditions to protect the public

(1) The Board must, if at any time it is satisfied that such action ***is necessary*** *for the purpose of protecting the life or physical or mental health of any person:*

(a) by order suspend a registered medical practitioner from practising medicine for such period (not exceeding 8 weeks) as is specified in the order, or

(b) impose on a registered medical practitioner's registration such conditions, relating to the practitioner's practising medicine, as it considers appropriate.

It was altered significantly in 2008, in response to the scandal surrounding the obstetrician and gynaecologist, Dr Graeme Reeves.

After the amendment, section 66(1) of the *Medical Practice Act* read as follows:

(1) The Board must, if at any time it is satisfied that ***it is appropriate to do so*** *for the protection of the health or safety of any person or persons (whether or not a particular person or persons****) or if satisfied that the action is otherwise in the public interest****:*

(a) by order, suspend a registered medical practitioner from practising medicine for such period (not exceeding 8 weeks) as is specified in the order, or

(b) impose on a registered medical practitioner's registration such conditions relating to the practitioner's practising medicine as the Board considers appropriate.

The two most significant changes

There are two particularly significant changes. The first is a change to the threshold at which action can be taken for the protection of the public. The Board no longer needs to be satisfied that suspension is necessary. Instead, they need only consider whether it is appropriate.

The second is the introduction of another basis for suspension or conditions; the words *"or otherwise in the public interest"*.

The amending Act made a further change

In addition, section 2A of the *Medical Practice Act* was amended.

Previously it read;

(1) The object of this Act is to protect the health and safety of the public by providing mechanisms designed to ensure that:
(a) medical practitioners are fit to practise medicine, and
(b) medical students are fit to undertake medical studies and clinical placements.
(2) The Board must exercise its functions under this Act in a manner that is consistent with this object.

After the amendments it read;

(1) The object of this Act is to protect the health and safety of the public.

(2) The object of this Act is achieved by providing mechanisms designed to ensure that:

(a) medical practitioners are fit to practise medicine, and

(b) medical students are fit to undertake medical studies and clinical placements.

(3) **In the exercise of functions under this Act the protection of the health and safety of the public is to be the paramount consideration.**

The National Law as implemented in NSW incorporates each of these changes

The current wording of section 150 (1) of the *National Law* applies essentially the same test, and section 3A, of the National Law reproduces the requirement that the health and safety of the public be the *"paramount consideration"* when performing functions under the National Law.

The wording of these provisions in the *National Law* as implemented in NSW is taken directly from the former *Medical Practice Act*.

The combined effect of these provisions is that there is a broad discretion to take action to protect the health and safety of the public, including suspension, and there is a power to do so where it is in the public interest, for reasons other than the protection of the health and safety of the public.

Some comments on the tightening of these provisions

Point one; there is a reason why interim action should not go beyond what is necessary for the protection of the health and safety of the public

A couple of points should be made. The first is that the previous limitation on the exercise of the power to circumstances where taking action was necessary for the protection of the health and safety of the public reflected the fact that a full investigation had not been conducted, and the facts had not been determined.

Imposing significant restrictions, most significantly suspension, without a full investigation, response from the practitioner, a full hearing, and a determination, comes at a significant cost to the practitioner him or herself.

Point two

The second point is that an independent *"public interest"* power introduces a much wider discretion, a greater degree of subjectivity, and a greater degree of unpredictability of decision-making.

The Supreme Court has said that it *"includes considerations of maintaining public confidence in the scheme for regulating health practitioners…and that practitioners will exhibit traits consistent with the honourable practice of an honourable profession"*, and that it covers *"wider community interests such as the standards to which human conduct is to be held"*.[1]

In *Prakash v HCCC* [2006] NSWCA 153 at [91], Justice Basten opined that;

"...the public interest includes indirectly, the standing of the medical profession and the maintenance of public confidence in the high standard of practitioners. There is also an element of deterrence or, to put it more positively, encouragement to other practitioners to recognise the importance of complying with professional standards and the risks of failing to do so."

<u>Use of the public interest power to take interim action</u>

Case study one; Dr Crickitt

The public interest power was used most strikingly to suspend Dr Crickitt. At the time of his suspension, he had been charged but not convicted, of murdering his wife. He was also her treating doctor. The allegation was that he had administered a lethal dose of insulin.

No conviction; indeed, Dr Crickitt had pleaded not guilty, and strenuously maintained his innocence. While he should not have been his wife's treating doctor, and there are possibly question marks about the quality of the treatment he provided to her, there was no obvious threat to the health and safety of the public. The one patient he might have been a risk to was dead.

---

[1] *Pharmacy Council of NSW v Ibrahim* [2020] NSWSC 708 at [32] and [35].

But is it in the public interest to allow a doctor very publicly and rather sensationally charged with murdering his wife to continue in medical practice? Would you send your partner, your parent, your child, to be treated by him?

The Medical Council, exercising its section 150 powers, tackled the problem head on. They said that while they had *"no immediate concerns*" that Dr Crickitt's practice of medicine posed a clinical risk to the health and safety of the public:

"….the seriousness of the allegations and the potential for the reputation of and trust in the medical profession to be damaged provide cogent reasons for taking action in the public interest, at least while the criminal proceedings are pending."[2]

Dr Crickitt appealed to the Tribunal. The Tribunal, perhaps uncertain of the scope of the *"public interest"* power, chose the equivalent of gaoling Al Capone for tax fraud.

The Tribunal grounded their decision in the more comfortable territory of public health and safety with reference to the inappropriateness of treating his wife, the absence of clinical records, deficiencies in his treatment of his wife which raised questions about the safety of his practice more generally, and dishonest statements to the police.

Exploration of the *Crickitt* decisions

The facts of *Crickitt* tells us something about the limitations of the off-field/on-field distinction, while the contrasting approach taken by the Medical Council as opposed to the Tribunal, with the Medical Council grounding their decision in the "public interest" and the Tribunal in the health and safety of the public, may tell us something about these two powers, and help us to tease out their meaning.

---

[2] Reproduced in *Crickitt (No 2)* [2015] NSWCATOD 115, at [4].

Assume the following facts. Dr Crickitt did not treat his wife. He meticulously refused to write her a single prescription. His own practice was exemplary. Instead, he was charged with shooting and killing her.

The conduct can now no longer be related to his practise of medicine. It is now "off-field" behaviour. However, applying the public interest test, as the Medical Council did, it surely makes no difference to the outcome.

The problem is the seriousness of the conduct alleged. Murdering a spouse is so incompatible with the public perception of the qualities which a doctor should possess that the fact that there was sufficient evidence to warrant prosecution is sufficient to warrant suspension, regardless of whether his "on-field behaviour" is called into question, and regardless of whether the health and safety of the public is at risk.

It is in the *"public interest"* because allowing the doctor to continue while investigating the complaint undermines public confidence in the medical profession.

The *"public interest"* limb has also been used where there are pending charges involving family violence (see, for instance, *Hyland v Medical Council of NSW* [2021] NSWCATOD 167), or a failure to comply with conditions imposed at earlier hearings.

Case study two; Dr Pridgeon

A more controversial example is Dr Pridgeon, whom the Medical Council suspended on public interest grounds, a decision affirmed by the Tribunal on appeal[3].

As the Tribunal observed, the facts were extraordinary. Dr Pridgeon was the subject of no complaint from any patient or any practitioner about any aspect of his practice. Rather, the Medical Council suspended him after a highly publicised arrest by the AFP of *"child stealing"* and *"conspiracy to defeat justice at Townsville"*.

---

[3] *Pridgeon* [2021] NSWCATOD 89

Dr Pridgeon had played a central role in helping a mother conceal her twin daughters from their father, with whom the Family Court had ordered them to live.

I urge you to read the case. Dr Pridgeon believed the mother's allegation, which she had reported to police, that her daughters were being sexually abused by their father.

It is a little unclear, but it appears that the mother and her children were Dr Pridgeon's patients for several years.

Significantly, Dr Pridgeon had some evidence which provided some support for the allegation being made by the mother.

By the time of the Tribunal hearing, Dr Pridgeon continued to face serious charges as a result of his actions, which carried significant jail terms. However, there was no suggestion of ongoing conduct which could give rise to criminal charges, and Dr Pridgeon denied that he would behave similarly in the future.

The Tribunal said;

"*We accept, from the evidence of the Appellant and the manner in which he gave his evidence, that the Appellant was convinced of the veracity of the allegations made by and on behalf of the children, and was compelled by his empathy for the children and personal ethical view of life to do what he could to protect the children".*

They also recorded that Dr Pridgeon was *"unapologetic"* about what he had done, and was convinced that it was, if not his legal duty, his moral duty to protect them from assault from their father.

The Tribunal observed (at [195]) that the Appellant's case *"raised a real dilemma, which he effectively posed to the Tribunal members, namely 'what would society expect of a decent caring human being placed in the same situation"* as he was?

The Tribunal wrestled with this decision. However, ultimately they resolved the question with reference to the importance of the rule of law, which in this case, meant respecting the orders of the Family Court, and not taking the law into one's own hands.

They said that to *"disregard the law and taken steps to frustrate or defeat its purpose, moves a society into anarchy"* (at [196]).

Ultimately, they said, the public expects medical practitioners to behave "honourably", and that means *"to act lawfully at all times"* (at [202]). To allow Dr Pridgeon to continue in practice with such serious criminal charges pending would *"erode public confidence in the medical profession"* (at [208]).

It was therefore necessary, *"in the public interest"*, to affirm the decision to suspend Dr Pridgeon's registration.

I would be interested in the views of others about this particular outcome.

Whether conduct is "off-field" or "on-field", as a general rule the question is what that behaviour says about the practitioner's capacity to practice without risk to the health and safety public

More commonly, interim action (as opposed to final action) is taken with respect to alleged conduct occurring outside work because of what that behaviour says about the practitioner's capacity or fitness to practice, which in turn, creates a risk to the patients whom the practitioner treats.

This will be the case where the use of prescription or illegal drugs is a symptom of a serious underlying condition which affects the capacity of the practitioner to practice safely.

In some cases, this will result in referral to the Health Programme. In others, suspension.

Equally, aberrant or criminal behaviour may suggest a defect or failing which puts patients at risk, for instance allegations of sexual assault outside of the workplace.

Decisions based upon the public interest decisions remain the exception rather than the rule

Before opening up the conversation to others, I want to conclude with a general observation about interim hearings. Decisions based upon the "public interest" are the exception rather than the rule. Overwhelmingly, the issue is what is appropriate for the protection of the health and safety of the public.

Of course the conduct which formed the complaint and brought the matter to the attention of the Council is relevant, but overwhelmingly what leads to suspension is the way in which the practitioner interacts with the Council's delegates, and the manner in which they answer questions.

Tone, attitude, body language, and coherence of thought are almost more important than the conduct being considered and even the content of the doctor's responses.

While the statutory test relates to the health and safety of the public, the test is given focus by asking *"would I be comfortable with my partner, my parents, my children, seeing this doctor"*?

On an unconscious level, I believe that the less tangible characteristics I have referred to, what we lawyers might call the *"demeanour"* of the practitioner, but might also be called the "tone" or "register" of the practitioner play a major role in answering that question.

Before opening the discussion up to questions and comments from the floor, I will mention one particular example of how "tone" and "register" can be critical to the outcome in "urgent action" hearings.

The doctor in question was a very good orthopaedic surgeon who had made a very poor choice of partners, a partner whom he had treated not particularly long before the relationship began.

The poorness of his choice of partner became apparent when she made a salacious complaint which included allegations of drug-taking and violent behaviour which if the Council had seriously suspected were true would have resulted in significant restrictions on the doctor's ability to practice.

The doctor's evidence was impressive. He made appropriate concessions with respect to some poor choices. He dealt with the more salacious allegations firmly, but with equanimity, and without expressing any animosity towards the complainant.

In that case, it was the manner in which he handled questions, his tone, and his equilibrium which determined the outcome, not the gravity of the complaint.

In my experience, this is the rule rather than the exception.

Thank you.

Cameron Jackson
Second Floor
Selborne Chambers
Ph 0408 225 761